

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:

County Kent
City or town Chestertown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred:
Washington Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Kent
City or town Chestertown
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2. (a) If veteran, name war _____

3. (a) FULL NAME

Thomas Dodd Bowers

3. (b) Social Security Number

no

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
6. (b) Name of husband or wife Marion Lusby Bowers
living 6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) Nov. 13, 1868
8. AGE: Years 79 Months 7 Days 17 If less than one day _____ hrs. _____ min.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1948 at 7:15 P
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/10/48 to 7/1/48
and that I last saw him alive on 7/1/48
Immediate cause of death Cachexia & uremia
DURATION 2/weeks
Due to Urinary tract infection generalized DURATION 2 months
Due to Squamous cell carcinoma of prostate gland DURATION 5 months
Other conditions (known duration)

9. Birthplace Baltimore City, Maryland
(Town, county, and state)
10. Usual occupation News Reporter (retired)
11. Industry or business _____
12. Name Daniel Bowers
13. Birthplace Maryland
14. Maiden name Augusta Dodd
15. Birthplace Kent Co. Md.

16. Informant Mrs. Marion Bowers
Address Chestertown, Md.
17. Burial Date thereof July 4, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Chester Cem.
Chestertown, Md.
Location
18. Funeral director J. Willis Wells
Address Chestertown, Md.

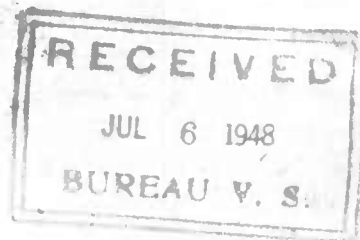
(Include pregnancy within 3 months of death)
Major findings of operations _____ Date of op. _____
Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____
23. SIGNATURE R. B. Barnes M. D. or other _____
Address Chestertown, Md. Date signed 7/2/48

19. July 3, 1948 Claudia Barnes
(Date rec'd by registrar) Registrar

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

JUL 6 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 07350 202

1. PLACE OF DEATH:

County Kent CoCity or town Still Pond md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 60 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County KentCity or town Still Pond md
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

John William Clark

3. (b) Social Security Number

218-12-12554. Sex Male5. Color or race White6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Mary E Clark6. (c) If alive, give age 63 years7. Birth date of deceased (mo., day, yr.) 1-23-18758. AGE: Years 73 Months 5 Days 18 If less than one day _____ hrs. _____ min.9. Birthplace Saspass md
(Town, county, and state)10. Usual occupation clerk11. Industry or business dry goods groceries12. Name Charles Clark13. Birthplace Kent Co md14. Maiden name Anna Matilda Hill15. Birthplace Kent Co md16. Informant Mrs Mary E ClarkAddress Still Pond md17. Burial Date thereof July 11/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Still Pond mdLocation Still Pond md18. Funeral director B R WillowsAddress Still Pond md19. July 12 48 Clara S. Barnes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 1948 at 4:10 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 1948 to July 11 1948and that I last saw him alive on July 11 1948Immediate cause of death Angina Pectoris

Due to _____

Due to acute cold

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Antopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE L. P. AlwellAddress Still Pond M. D. or other _____Date signed 7/12/48

UNITED STATES DEPARTMENT OF JUSTICE
BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

6-41
1948-X-7X
73-3-18
1973-1-23

RECEIVED

JUL 14 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

164C

07351

CERTIFICATE OF DEATH

Reg. Dist. No. 203

1. PLACE OF DEATH:

County MontgomeryCity or town Rock Hill
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? all the timeHospital, institution, or street address where death occurred: homeHow long in hospital or institution? none

3. (a) FULL NAME

William Henry Coleman

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Nov. 14, 1887

8. AGE:

Years

Months

Days

If less than one day

60722

hrs.

min.

9. Birthplace

Cherrytown and

10. Usual occupation

waterman

11. Industry or business

Grabbage taking

12. Name

Rich Coleman

13. Birthplace

Montgomery

14. Maiden name

Supina Dobson

15. Birthplace

Calabash, N.C.

16. Information

Spouse, Son

Address

Rock Hill, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

July 7, 1948

Cemetery or crematory

Wesley Chapel

Location

Rock Hill, Md.

18. Funeral director

Edgar L. Lane

Address

Blunch Hill, Md.

19.

(Date rec'd by registrar)

19.

48

Silverwood-Burgess

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

City or town

Rock Hill
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

2D. DATE OF DEATH

July 5, 1948

I CERTIFY that death occurred on the date above stated, that I attended deceased from

from 1948 until deathand that I last saw him on July 5, 1948Cause of death Heart failure

DURATION

Heart failure

RECEIVED

JUL 15 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:

County Kent
 City or town Chestertown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 year
 Hospital, institution, or street address where death occurred:
305 Cannon St
 How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Kent
 City or town Chestertown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 305 Cannon St
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Susie Virginia Conyer

3. (b) Social Security Number

4. Sex Female 5. Color or race col 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Archie Conyer
 6.(c) If alive, give age 54 years
 7. Birth date of deceased (mo., day, yr.) June 24 1893
 8. AGE: Years 55 Months 0 Days 24 If less than one day
hrs. min.

9. Birthplace Chestertown
 (Town, county, and state)
 10. Usual occupation House
 11. Industry or business -

12. Name William Johnson
 13. Birthplace Maryland
 14. Maiden name Eunice Reese
 15. Birthplace Maryland

16. Informant Lucille Warren
 Address 305 Cannon St Chestertown
 17. Burial Date thereof July 24-1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematorium Mount Lebanon
 Location Philadelphia
 18. Funeral directed by Asbury H. H. H. H.
 Address Chestertown Md.

19. July 31 1948 Clara S. Barnes
 (Date read by registrar) Registrar

MEDICAL CERTIFICATION

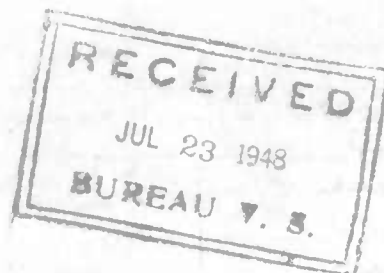
20. DATE OF DEATH July 18 1948 at 2 30 A M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
July 4 1948 to July 18 1948
 and that I last saw him alive on 7-17 1948

Immediate cause of death chronic Endo-lycorardial
decompensation
arteriosclerosis
Hypertension
 Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Albert A. Burgard M. D. or other
Rock Hall, Md. Date signed 7/20/48
 Address.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07353

Reg. Dist. No. 202

1. PLACE OF DEATH:

County Stell
 City or town Steel Pond
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 12 hours
 Hospital, institution, or street address where death occurred:

How long in hospital or institution? now

3. (a) FULL NAME

Walter Hayes Davis4. Sex male 5. Color of race white 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) June 6, 1898 8. (c) If alive, age now years8. AGE: Years 10 Months 1 Days 4 If less than one day hrs. min.9. Birthplace Middleton, Del. (Town, county, and state)10. Usual occupation Post office11. Industry or business Post office12. Name Walter Hayes Davis13. Birthplace Middleton, Del.14. Maiden name Hayes15. Birthplace Middleton, Del.16. Information nowAddress Still Pond, Md.17. Burial Date thereof July 14, 1948 (month) (day) (year)Cemetery or crematory Methodist ChurchLocation Middleton, Del.18. Funeral director B. R. FellowsAddress Still Pond, Md.19. July 12, 1948 Clara S. Barnes Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Stell
 City or town Steel Pond
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. now
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10, 1948 at 5:30 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from birth to death and that I last saw him alive on July 10, 1948Immediate cause of death congenital med. defect DURATIONDue to congenital obstructionDue to the sameOther conditions now

(Include pregnancy within 9 months of death)

Major findings of operations nowDate of op. nowAutopsy results now

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide now Date of nowWhere did injury occur? now (City or town) (County) (State)Injured at home, farm, industry, public place (where?) nowMeans of injury now Injured at work? nowSignature Clara S. Barnes M. D. or otherAddress Still Pond, Md. Date signed July 14, 1948

RECEIVED

JUL 14 1948

BUREAU V. S.

Evidence for addition of
name and change of age and
birth date shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07354

FILM No. G 11 JUL 27 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:

County Kent
City or town Chester town
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 days
Hospital, institution, or street address where death occurred:
Kent and Queen Annes
How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Kent
City or town (Rural) Worton
(If outside city or town limits, write RURAL and give nearest town)
Street No. near Worton
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Otho Frank Fogwell

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Hallie M Fogwell

7. Birth date of deceased (mo., day, yr.) October 27, 1888

8. AGE: Years 67 Months 6 Days 21 If less than one day

9. Birthplace Kent County, Maryland
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Agriculture

12. Name Otho F. Fogwell

13. Birthplace Rock Hall Md.

14. Maiden name Manda S. Harper

15. Birthplace Maryland

16. Informant Mrs. Hallie M. Fogwell

Address Worton Md Rural

17. Burial Date thereof July 21, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Chester

Location Chester town, Md.

18. Funeral director B. R. Holloway

Address Still Pond Md

19. July 20 19 48 Clara S. Barnes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 19 48 at 8:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 19 48 to July 18 19 48

and that I last saw him alive on July 18 19 48

Immediate cause of death Circulatory collapse

Due to Metastatic carcinoma 3 mos?

Due to Carcinoma of prostate 1 year?

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. D. Vicks, M.D. M. D. or other

Address Chester town, Md. Date signed 7-18-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 22 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of
birth date shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FILM NO. G 116 AUG 10 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 07355 202

1. PLACE OF DEATH

County Kent
City or town Kennedyville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life time
Hospital, institution, or street address where death occurred: no
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Kent
City or town farm near Kennedyville
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Robert Raymond Hill

3. (b) Social Security Number

4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Adler S. Hepton

7. Birth date of deceased (mo., day, yr.) November 12 - 1878 6.(c) If alive, give age 71 years

8. AGE: Years 74 Months 10 Days 12 If less than one day _____ hrs. _____ min.

9. Birthplace Port Kennedy Pa
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Danish Hill

13. Birthplace Pa

14. Maiden name Mary J. Kelpatriek

15. Birthplace Pa

16. Informant Raymond Hill

Address Kennedyville, Md

17. Burial Date thereof Aug 1 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Still Pond

Location Still Pond, Md

18. Funeral director B. D. Holloway

Address Still Pond, Md.

19. July 31 19 48 Claude Barnes
(Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 19 48 at 4 9 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1935 to July 2 19 48

and that I last saw deceased alive on _____ 19 _____

Immediate cause of death _____ DURATION 20 years

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Frank W. Smith M. D. or other _____

Address Chesapeake Date signed July 30/48

RECEIVED

AUG 3 1948

BUREAU V. 3.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 202

07356
203

1. PLACE OF DEATH

County NeutCity or town Rock Hall
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 hour

Hospital, institution, or street address where death occurred:

How long in hospital or institution? None

3. (a) FULL NAME

Louis Lawrence Hoffmann

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Caroline Grace Hoffmann

7. Birth date of deceased (mo., day, yr.)

Jan 26, 1896

6. (c) If alive, give age _____ years

8. AGE:

18 Years 6 Months 14 Days If less than one day _____ hrs. _____ min.

9. Birthplace

Newark, N. J.
(Town, county, and state)

10. Usual occupation

Ironman Branch Plant

11. Industry or business

Robby Bros. Inc.

12. Name

Louis Jacob Hoffmann

13. Birthplace

Newark, N. J.

14. Maiden name

Caroline Schwell

15. Birthplace

Newark, N. J.

16. Address

891 Roy Br. Union N. J.

17. Burial

(Burial, cremation, or removal. Which?)

Union Cem.

Cemetery or crematory

Union County, New Jersey

Location

J. Willas Wells

18. Funeral director

Chestertown, Maryland

Address

July 11, 1948Class S. Barnes

Date filed by Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Md County NeutCity or town Rock Hall
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

MEDICAL CERTIFICATION

2D. DATE OF DEATH Jul 10 19 48 at 4 P M

CERTIFY that death occurred on the date above stated; that I attended deceased from

death signed certificateas deputy medical examiner

DURATION

myocardialCoronaryobstructionseveralmonthsDue toDue toOther conditions(Include pregnancy within 8 months of death)Major findings of operationsnoDate of op.Autopsy resultsPHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:Accident, suicide, or homicideWhere did injury occur?Injured at home, farm, industry, public place (where?)Mean of injuryInjured atAddressDateDeathDeathDeathDeathDeathDeathDeath

RECEIVED

JUL 15 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

922 07357

Reg. Dist. No. 202

1. PLACE OF DEATH:

County..... Kent
 City or town..... Haynesville near St. James
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... April 1948
 Hospital, institution, or street address where death occurred:
House
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Kent
 City or town..... Haynesville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... near St. James Church
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Thomas J. Haldson
 4. Sex..... M. 5. Color or race..... Wh. 6.(a) Single, married, widowed, or divorced..... widowed

B.(b) Name of husband or wife

Etta Haldson
 B.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... Nov 16 1875

8. AGE: Years..... 72 Months..... 7 Days..... 14 If less than one day..... hrs. min.

9. Birthplace..... Haynesville
 (Town, county, and state)

10. Usual occupation..... Farming

11. Industry or business..... Retired

12. Name..... Robert Haldson

13. Birthplace..... Kent Co. Md.

14. Maiden name..... Elizabeth Sullivan

15. Birthplace..... Kent Co., Md.

16. Informant..... Mrs. Susie Haldson

Address..... Worton, Md.

17. Burial Date thereof..... July 4, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or cremation..... Union

Location..... Worton, Kent Co. Maryland

18. Funeral director..... Morris V. Williams

Address..... Christine, Maryland

19. July 3 1948 Clark S. Barnes
 (Date rec'd by registrar) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH..... July 1 1948 at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Beginning of April 1948 to July 1 1948
 and that I last saw him..... alive on June 25 1948

Immediate cause of death.....
chronic end myocarditis
decompensation
angina pectoris
coronary sclerosis
 Due to.....
arthritis
 Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....

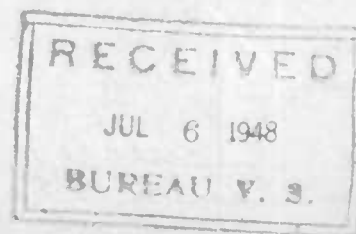
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Albert A. Burgard M. D. or other

Address..... Rock Hall, Md. Date signed..... 7/1/48



VS A15

1000

10 July 13 1848 Clara S. Barnes

RECEIVED

JUL 15 1948

BUREAU Y. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 07359 202

1. PLACE OF DEATH:

County KentCity or town Still Pond Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 years

Hospital, institution, or street address where death occurred: _____

How long in hospital or institution? _____

3. (a) FULL NAME

Herbert Jones4. Sex Male 5. Color or race C 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Malinda Jones7. Birth date of deceased (mo., day, yr.) June 30 - 18816. (c) If alive, give age 67 years8. AGE: Years 67 Months - Days 27 If less than one day _____ hrs. _____ min.9. Birthplace Kent Co Md.
(Town, county, and state)10. Usual occupation Labor11. Industry or business Farm work12. Name John Jones13. Birthplace Maryland14. Maiden name Mary Butler15. Birthplace Maryland16. Informant Reba Lillian JohnsonAddress Still Pond Md.17. Burial Date thereof July 30 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rural Fountain MortuaryLocation Morton Md Rural18. Funeral director B. R. WellowsAddress Still Pond Md.19. July 30, 1948 Clara S. Barnes
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County KentCity or town Still Pond Md
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number _____

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1948, at 5:20 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1948, to July 1948and that I last saw him alive on July 27 1948Immediate cause of death Bronchial Asthma DURATION 1 yrarterial sclerosis

Due to _____

Due to _____

Other conditions Scotial Hernia

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE L. P. Alwell M. D. or otherAddress Still Pond Date signed 7/28/48

RECEIVED

AUG 2 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 203

1. PLACE OF DEATH:

County... Kent
 City or town... Rock Hall - Home
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?...

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Kent
 City or town... Rock Hall
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... Home
 (If rural, give LOCATION)
 2.(a) If veteran, name war...

3. (a) FULL NAME

Thomas Indefind

3. (b) Social Security Number

4. Sex

m.

5. Color or race

Wh.

6. (a) Single, married, widowed, or divorced

single

B. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Sept 22 1872

6. (c) If alive, give age... years

8. AGE:

Years

75

Months

9

Days

20

If less than one day

hrs.

min.

9. Birthplace

Washington D. C.
(Town, county, and state)

10. Usual occupation

carpenter

11. Industry or business

retired

FATHER

12. Name

John W Indefind

13. Birthplace

Maryland

14. Maiden name

Parah F. Bruff

15. Birthplace

Maryland, Kent Co.

16. Informant

Uncles Hyson

Address

Rock Hall, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

July 14 48
(month) (day) (year)

Cemetery or crematory

Wesley Chapel

Location

Rock Hall, Md.

18. Funeral director

Edgar R. Lane

Address

Chestertown

19.

(Date rec'd by registrar)

7/3 48S. Elwood Binger

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 12

19

48 at 5:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7/8

19

48to 7/12

19

48

and that I last saw him alive on

7/12

19

48

Immediate cause of death

chron. endo-arteriosclerosis
decompensation

DURATION

Due to

arteriosclerosis

Due to

hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Arthur A. Burgard

M. D. or other

Address

Rock Hall, Md.

Date signed

7/13/48

RECEIVED

JUL 15 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coroner's age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

07361

Reg. Dist. No. 202

1. PLACE OF DEATH:

County.....

City or town.....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematorium

Location

18. Funeral director

Address

19.

Date read by registrar

1948

Class L. Barnes, Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

19

at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, pub'l'c place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

RECEIVED

JUL 22 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

07362

200

1. PLACE OF DEATH:

County Kent
 City or town Parrat Millington
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days
 Hospital, institution, or street address where death occurred: _____

How long in hospital or institution? _____

3. (a) FULL NAME

Emeline A Priest

3. (b) Social Security Number

none

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) March 21 1892 6. (c) If alive, give age _____ years

8. AGE: Years 56 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Delaware
 (Town, county, and state)

10. Usual occupation Housework

11. Industry or business _____

12. Name unknown13. Birthplace unknown14. Maiden name unknown15. Birthplace unknown16. Informant Charles H. Priest (son)Address Wilmington Del

17. Burial Date thereof Aug 4 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory mt zionLocation Wilmington Del18. Funeral director Edward F. BellowsAddress Millington Md

19. July 30 19 48 Edward F. Bellows
 (Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new-born infants give residence of mother)
 State Del. County New Castle

City or town Wilmington
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION) ☒

2. (c) If veteran, name war _____

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 19 48 at 9²⁰ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 29 19 48 to July 30 19 48

and that I last saw him alive on July 29 19 48

Immediate cause of death Acute dilatation of Heart DURATION _____

Due to Asthma

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

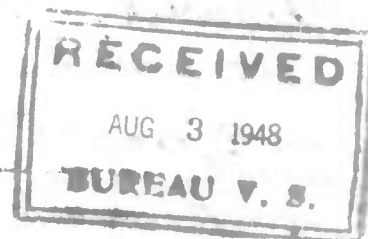
Where did injury occur? _____
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE H. H. Hamilton M. D. _____

Address Millington Md Date signed July 30 48



RECEIVED

AUG 3 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

466

07363

Reg. Dist. No. 202

1. PLACE OF DEATH:

County KentCity or town Chestertown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Kent + Queen Anne General

How long in hospital or institution?

25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County KentCity or town Kennedysville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Joseph Sindle Rhoades

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

8. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Sidie C. D. Rhoades

5. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.) March 16, 1869

8. AGE:

Years

79

Months

3

Days

26

If less than one day

hrs.

min.

9. Birthplace

Chesapeake City, Cecil, Maryland.
(Town, county, and state)

10. Usual occupation

Retired merchant

11. Industry or business

FATHER

12. Name

William H. Rhoades

13. Birthplace

Maryland

MOTHER

14. Maiden name

Martha Bryley

15. Birthplace

Maryland

16. Informant

Mrs. Joseph L. Rhoades

Address

Kennedysville, Md.

17.

Burial
(Burial, cremation, or removal, Which?)

Date thereof

7/15/48
(month) (day) (year)

Cemetery or crematorium

Location

18. Funeral director

Address

Middletown Del.

19.

July 14
Date read by registrar

19. 48

19. 48

19. 48

19. 48

19. 48

19. 48

19. 48

19. 48

19. 48

19. 48

19. 48

19. 48

19. 48

19. 48

19. 48

19. 48

19. 48

19. 48

19. 48

19. 48

19. 48

19. 48

19. 48

19. 48

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 12 19. 48, at 9:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5-15 19. 48, to 2-12 19. 48and that I last saw him alive on 2-12 19. 48

Immediate cause of death

Carcinoma of stomach

DURATION

Unknown

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE

R. H. W. Furr

M. D. or other

Address Chestertown, Md. Date signed July 13, 1948

RECEIVED

JUL 16 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 203

1. PLACE OF DEATH:

County Kent
 City or town Rock Hall
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? life
 Hospital, institution, or street address where death occurred:
Galitude Rd.
 How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Kent
 City or town Rock Hall
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Galitude Rd.
 (If rural, give LOCATION)
 2.(a) If veteran, name war -

3. (a) FULL NAME

George Tilden Urie

3. (b) Social Security Number

4. Sex m. 5. Color or race Wh. 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Bessie Urie6. (c) If alive, give age 70 years7. Birth date of deceased (mo., day, yr.) Aug 22 1877

8. AGE: Years 70 Months 10 Days 7 If less than one day - hrs. - min. -

9. Birthplace Rock Hall Md.
(Town, county, and state)10. Usual occupation Foreman11. Industry or business Self.12. Name William Urie13. Birthplace Rock Hall, Md.14. Maiden name M. Elizabeth Joiner15. Birthplace Rock Hall16. Informant Wm. Bessie UrieAddress Rock Hall, Md.17. Burial Date thereof Jan 1 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Wesley ChapelLocation Rock Hall Md.18. Funeral director W. L. LauerAddress Church Hill, Md.19. July 31 - 1948 S. Howard Bunker
(Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1948 at 3:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7:29/48 2:10 P.M. to 7:29/48 3:05 P.M.
 and that I last saw him alive on 7/29/48 19 -

Immediate cause of death

Cerebral hemorrhage
Hypertension

Due to Cerebral hemorrhage (chronic)Due to arteriosclerosisOther conditions -

(Include pregnancy within 3 months of death)

Major findings of operations -Date of op. -Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -Where did injury occur? - (City or town) - (County) - (State)Injured at home, farm, industry, public place (where?) -Means of injury - Injured at work? -23. SIGNATURE Robert H. Bunker M. D. Wesley ChapelAddress Rock Hall, Md. Date signed 7/29/48

MARGIN RESERVED FOR BINDING

I

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 9 1948

BUREAU W. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07365

Reg. Dist. No. 200

1. PLACE OF DEATH:

County KentCity or town Rural Millington
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 30 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County KentCity or town Rural Millington
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Bessie Jane Wallace

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) April 16 1882

6. (c) If alive, give age _____ years

8. AGE:

66

Months

Days

If less than one day

hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

48

Edmund Fellows

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 19 48, at 6:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 28 19 48 to July 7 19 48
and that I last saw him alive on July 6 19 48Immediate cause of death Cardiac Decompen-
sation.

DURATION

Due to Arteriosclerotic Heart Disease

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

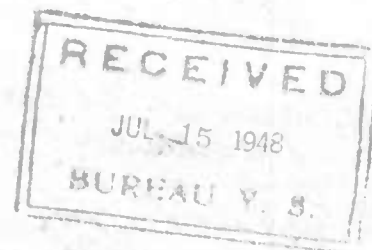
Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. H. Hamilton

M. D. or other

Address MillingtonDate signed July 9/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

07366

CERTIFICATE OF DEATH

Reg. Dist. No. 204

1. PLACE OF DEATH:

County Kent
City or town Fairlee
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life time
Hospital, institution, or street address where death occurred:
no
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Kent
City or town Brown
(If outside city or town limits, write RURAL and give nearest town)
Street No. Chesapeake R.R.
(If rural, give LOCATION)
2(a) If veteran, name war 2nd

3. (a) FULL NAME

Ida Loretta Walley

3. (b) Social Security Number

no

4. Sex Female 5. Color or race Col 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife William Walley

7. Birth date of deceased (mo., day, year) December 21 - 1887 6. (c) If alive, give age 59 years

8. AGE: Years 60 Months 6 Days 14 If less than one day hrs. min.

9. Birthplace Fairlee Kent Co
(town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Joseph J. J. J. J.

13. Birthplace Kent Co Md

14. Maiden name Joseph J. J. J. J.

15. Birthplace Kent Co Md

16. Informant William Walley

Address Fairlee Chesapeake

17. Burial, cremation, or removal, Which? Buried Date thereof July 7 / 48
(month) (day) (year)

Cemetery or crematory Fairlee

Location Fairlee Chesapeake

18. Funeral director Asbury Henry

Address Chesapeake

19. July 7 1948 J. W. Smith Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1948, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 4 1948

and that I last saw him alive on July 4 1948

Immediate cause of death Secondary Cancer

Due to Cancer of Breast

Due to Metastases into

Other conditions breast

(Include pregnancy within 3 months of death)

Major findings of operation Cancer of Breast

removed Date of op. 1945

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Injured at work?

Means of injury Injured at work?

23. SIGNATURE Frank W. Smith M. D. or other

Address Chesapeake Date signed July 7 / 48

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line for age is especially important. Physicians: please write the causes of death clearly and legibly.

